A SYSTEMS APPROACH TO THE TREATMENT OF CHEMICAL ADDICTION*

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ABSTRACT: Therapists are increasingly considering chemical addiction from a family systems perspective. Effects of chemical dependency upon the family are discussed and intervention approaches aimed toward assisting the family as families redefine themselves and change their structure are considered. The integration of chemical dependency treatment and the family therapy is also discussed as it is practiced in an intensive outpatient program at a psychiatric hospital.

KEY WORDS: chemical addiction; family systems; family therapy; 12-step programs.

Chemical addiction is defined in the *Diagnostic and Statistical Manual of Mental Disorders* under the term Substance Dependence, 304.9, and may be qualified with various specific descriptors to indicate the particular substance upon which the individual is dependent (American Psychiatric Association, 1994). Criteria for such a diagnosis are the development of a tolerance to the drug of choice, withdrawal from the drug when using ceases, physiological and psychological craving for the drug as well as an inability to control use, and/or continued use in the face of resulting difficulties. For the purposes

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of this paper, substance abuse and chemical addiction will be used to refer to both drug addiction and alcoholism.

The purpose of this paper is to provide a brief overview of chemical dependents and their families, examine chemical addiction through a family systems approach, and suggest a plan of care integrating individual, family, and group therapy for families with members who are chemically dependent.

A great deal of research has examined the types of therapies most effective in combating chemical addiction and promoting recovery. The evidence seems to suggest that effective treatment should include an integrative approach encompassing some degree of family therapy and other modes of treatment: individual and group therapy along with a 12-step follow-up program such as the one developed by Alcoholics Anonymous (AA) (McNabb & DerKarabetian, 1989; Joanning, Quinn, Thomas, & Mullen, 1992; Stanton & Todd, 1982; Edwards & Steinglass, 1995).

FAMILY DYNAMICS

Chemically dependent families live in an environment warped by substance abuse. Inconsistent behaviors abound and there is a sense of a lack of rules within the family system (Isaacson, 1991a). For example, the spouse may make excuses when the abuser has overindulged in alcohol or drugs. The spouse might call the addict's employer and claim illness on the part of the addict. However, at the same time, the spouse may tell the children that they should never lie. Over time, the spouse usually begins to feel resentment toward the addict due to his or her lack of consideration for the family. The spouse may also feel shame about his or her own enabling behaviors, such as lying to the boss and friends and being "two-faced" with the children. Such self-anger and shame may develop into depression in some cases.

Children of chemical dependents often display a type of hypervigilance in that they constantly watch the adults in their family for cues as to what types of subjects may be brought up without fear of retribution (Isaacson, 1991a). For example, before bringing up a school field trip for which five dollars is needed, a child may watch the parents intently throughout most of a meal and place a few feelers regarding kids at school and parents giving them money. If the child receives a negative reaction about the topic, he or she will prob-

ably drop it rather than risk the wrath of the parents by requesting money. This hypervigilance is harmful because it often results in anxiety and insecurity regarding the environment due to the unpredictability of the parents. Such a condition seems normal to children of chemical dependents. Indeed, these children have developed an equilibrium in the family system by embracing the addiction and incorporating it into the basic functioning of the system. As long as things stay the way they have always been, everyone knows how to manipulate the situation to get their needs met. The children, and indeed all of the family members, do not have to deal with anything unfamiliar and unexpected. In this system, they develop a way to "survive the disease" (Starr, 1989).

Chemically dependent families tend to have boundaries that are either too rigid or virtually non-existent (Mackenson & Cottone, 1992). This is unhealthy because it creates isolation or enmeshment of family members. Isaacson (199la) explains that such families tend to engage in behaviors which squelch individuation and promote continued use of chemicals by encouraging oppression or enabling using behaviors. Such families are characterized by rigid resistance to outside influences, multi-generational addiction, and firm adherence to homeostasis. The three main rules of addicted families are "don't trust," meaning that it is unwise to believe that what is good today will necessarily be good tomorrow, "don't feel," many family members of addicts are punished physically or emotionally for expressing any emotion such as anger or happiness. The third family rule is "don't talk," which implies that expressing oneself, within or outside of the family, could result in retribution (Isaacson, 1991a). Consequently, members have difficulty expressing emotions, processing troubles, and achieving intimacy. The basic emotions experienced, although rarely expressed, tend to be anger, shame, guilt, and depression. These emotions often become the regular response to any situation the person experiences (Isaacson, 1991a).

TREATING FAMILIES OF CHEMICAL DEPENDENTS

While therapists strive to maintain objectivity when assisting their clients, personal opinions can both impede and enhance their therapeutic strategies. There are several possible types of opinions that therapists may experience as they work with chemical dependents. Some may feel disgust because of some past experience with

the disease. Others may view it as a moral or judgment issue in that the client simply needs to say "no" and refrain from using chemicals. Still others may feel much empathy for the addict because they are able to tune into the battle with which the client is struggling. Zygarlicki and Smith (1992) assessed the level of empathy, disgust, and judgment in marriage and family therapists. In a sample of 257 therapists in the Midwest, 69% believed that alcoholism is a disease, not a moral issue. The preferred treatment was reported as a combination of individual, family therapy, and Alcoholics Anonymous. Most of the therapists believed that the use of Alcoholics Anonymous' 12-step programs is important and should be included in the recovery repertoire. While the preferred treatment modality appears to be a combination of individual, family, and group therapy, the majority of the family therapists viewed family therapy by itself as the next best choice should the three components be impossible to access. Overall, marriage and family therapists appear to be increasingly accepting the disease concept of alcoholism and joining chemical dependency professionals in following the Alcoholics Anonymous guidelines of abstinence for recovery (Zygarlicki & Smith, 1992).

Family Involvement in Treatment and Recovery

One question often raised is the necessity of family involvement in treatment and recovery from chemical dependence. In order to address this question, McNabb and DerKarabetian (1989) compared three groups to ascertain whether family therapy actually made any difference for the recovering addict. The three groups differed only in amount of family involvement in therapy. One group had no family involvement, a second group had partial family involvement, and a third had extensive family involvement in the treatment process. Those individuals in the group with the greatest family participation reported higher numbers of clients abstinent after six months. Subjects from the high family involvement group also claimed to have "better or much better" family relationships, more positive self-concepts, and even better physical health. Interestingly, those people who reported the most positive outcomes were also those that had longer term addiction and a greater number of past relapses. The authors concluded that there appears to be a strong relationship between family involvement and healthier recovery (McNabb & DerKarabetian, 1989).

Other studies have also supported the need for family therapy in

chemical dependency treatment. Regarding the issue of health, Stanton and Todd (1982) found in their research of families engaged in chemical dependency treatment that chemical dependents who did not participate in family therapy displayed a greater incidence (10%) of untimely deaths than clients who did involve their families (2%). Joanning, Quinn, Thomas, and Mullen, (1992) considered three chemical dependency treatment models for adolescents: 1) structural and strategic family systems therapy, 2) adolescent group therapy, and 3) family drug education. The results of this study showed that participants in the first model exhibited less drug use six months post-treatment than the other two groups. In fact the percentage of those clients with clean urine specimens were 50%, 20%, and 30% respectively. The writers have concluded from these findings that among adolescents, family systems therapy is not only a viable, but also a more effective method of chemical addictions therapy. Additionally, due to interviews with the clients, the researchers also state that family therapy may also decrease maladaptive behaviors manifested prior to treatment (Joanning et. al, 1992).

Edwards and Steinglass (1995) undertook a meta-analysis of research related to family therapy as a treatment modality with chemical dependents. They discovered that at times there was only marginal efficacy of family therapy as a tool to combat alcoholism. The authors warn that while preliminary findings seem to show drastic changes in actual drinking behavior soon after treatment, there are actually other factors which intervene in treatment outcomes. These factors include spousal motivation to make changes in their relationship, gender of the alcoholic, commitment to the marriage, and family support for recovery. If the spouse of the chemical dependent has actively sought help, that spouse is more likely to be of benefit to the client than were he or she to be asked to attend family therapy as part of the client's program. Additionally, the authors explain that male alcoholics seem to reap larger gains from family therapy than female clients. Females appear to perform just as well in an individual therapy program. If each spouse's desire to have a strong marriage is not at a high level, but rather they have come to the point where they no longer care to try and work things out, family therapy may not be so beneficial. Finally, according to the review, if the family environment in which the recovering chemical dependent lives is not conducive to adapting old negative behaviors into new and healthier behaviors, family therapy may not be appropriate. The family should be invited to explore its dynamics together in order to highlight those

negative behaviors which actually perpetuate the active drinking/using behavior. If the family is able to participate in this process, and acknowledge where changes need to be made, then they do become valuable collaborators in the therapy process (Edwards & Steinglass, 1995).

Structural and Strategic Therapy

A basic premise in the addiction field is that an individual is more likely to continue chemical use/abuse if fundamental family functioning does not readjust to the dynamics of recovery (Isaacson, 1991b). One might question how best to approach the family system in promoting recovery. Depending upon one's personal style, Isaacson (1991b) suggests that either structural or strategic family therapy can be effective. Before therapy becomes intense, Isaacson (1991a) maintains that the family should be assessed for the actual degree of chemical use, history of present and ancestral use, and patterns of dysfunctional interactions. Taking the time for such an assessment will usually reward the therapist with an overview highlighting areas needing attention.

From a structural view of the chemically addicted family, role reversal can occur among the parents and the offspring, disengagement or enmeshment is often fostered, and coalitions form. For example, a young child of the addict may become a caretaker when the addict has fainted due to overdose, and that child may become the "confidant" of the other parent. Consequently, the non-addicted parent and the addict may begin to emotionally pull away from each other, creating a more rigid boundary between them. As the boundary within the spousal subsystem becomes more rigid, the non-addicted parent may begin to increase the permeability of the boundary between himself or herself and the child, who is now the "confidant." Since all contribute to the continuation of the addiction, the structural therapist would take a directive position to assist the parents in regaining their position of setting and maintaining rules regarding treatment and enabling behaviors, i.e., those that promote continued substance abuse (Isaacson, 1991b).

The strategic therapist, on the other hand, might reframe the addictive behavior as being functional for survival at some time in the past, but as no longer desirable. In addition, enabling behaviors are considered loving gestures that are detrimental because they "love the client to death." Paradoxical interventions, such as asking the

parents/codependents to continue picking up the pieces and trying to control the client's life, are often used with a great deal of success (Isaacson, 1991b).

Both structural and strategic methods are effective in treating chemically addicted family systems. Structural therapy challenges the basic family organization and facilitates changes in roles and coalitions in order to hamper addictive behaviors. Strategic therapy works with the addiction dynamics as well, to cause disequilibrium in the system, thereby causing positive change during the equilibration process. Stanton and Todd (1982) posit that a structural-strategic combination plan designed across a short time duration can be quite productive in the treatment of chemical dependents and their family system.

Family Therapy and 12-Step Programs

Schroeder (1991) discusses the integration of family therapy and 12-step programs in the treatment process for chemical addiction. He states that the basic concepts of the 12-step programs, for example those of individual care-taking with some help from other program members and taking responsibility for personal actions, are quite similar to the tenets of family systems therapy. Schroeder maintains that including both family therapy and a 12-step program in the treatment process helps a client to focus on either individual issues or the group whenever appropriate. By including some individual intervention in each family session, the therapist can help family members understand each other in a safe context. In this manner, therapy can alleviate stress that may arise later in recovery as more "secrets" come out. The family will be a closer, healthier unit, and better able to process those difficulties as they arise. Basic involvement in a 12-step program will also insure that they have a support network to turn to at that time (Schroeder, 1991).

In light of the above discussion, it appears that there are several therapeutic approaches that can be effective in the treatment of chemical dependency and the families of the dependents. The assumption of this paper is that an integrative approach using individual, group, and family therapy and 12-step programs is highly effective. The final section of this paper discusses the approach taken in a local psychiatric hospital's intensive outpatient program, to elucidate how such an integrative approach might be facilitated.

THE MESILLA VALLEY HOSPITAL INTENSIVE OUTPATIENT PROGRAM

The Intensive Outpatient Program (IOP) at Mesilla Valley Hospital is designed to provide treatment to individuals with dual diagnoses, such as a type of chemical dependency in conjunction with major depression or bi-polar disorder. Such individuals must be at a level of functioning not necessarily requiring inpatient treatment, but necessitating more intensive therapy than regular outpatient visits to a therapist. This is ascertained after an intensive interview in which the client's ability to commit to abstinence from the use of chemicals is explored and the safety of the home environment is considered. If they are able to demonstrate a commitment to abstinence and have an environment relatively conducive to recovery, they may be enrolled in the IOP.

The program is designed for 60 hours of therapy encompassing individual, group, family, and multi-family therapy. The program usually takes six weeks to complete, but may be longer or shorter, depending upon individual need.

In weekly individual therapy, which usually encompasses four to six sessions and is scheduled at the client's convenience, the client focuses upon family of origin issues and personal diagnoses, such as major depression or borderline personality disorder, which may be exacerbated by the chemical dependency, and vice versa. The philosophy is that the chemical dependency is a symptom of a more pervasive distress which must be explored and addressed in order to lessen the motivation for chemical abuse. For example, an individual who suffers from major depression may find it very difficult to express anger and love to a spouse when sober. However, use of a mood-altering chemical often gives the individual enough courage to express himself or herself in an open manner. A significant problem, however, is that such expression is usually disinhibited, exaggerated, and often violent, resulting in confusion and hurt for the spouse. Individual therapy would also address any possible need for anti-depressant medication, personal self-esteem issues, and communication skills to aid in expressing oneself.

Group therapy is scheduled three times per week for six weeks, and meets in the evening in order to allow for clients' work schedules. The group setting is used as a "laboratory" of sorts, providing a safe place for the recovering chemical dependent to try out new coping skills learned in individual therapy. The group member is then provided feedback as to the effect of his or her behavior upon peers and

given suggestions by the group as to adjustments which might improve the impact of the new skills. In addition, group therapy allows the chemical dependent to develop a support network of fellow recovering dependents. Such alliances provide valuable assistance once the member has completed the program. Clients spend an average of 12 to 18 sessions with the group.

A weekly Aftercare Group is also provided at no charge, in which clients who have completed the IOP may choose to enroll and attend as long as they desire. This group also meets in the evening in order to accommodate work schedules. The Aftercare Group integrates clients from the current IOP group in order to begin developing some bonds for these clients prior to their discharge. All members of the Aftercare Group are required to attend Alcoholics Anonymous meetings or Narcotics Anonymous (NA) meetings, and are encouraged to obtain a sponsor. This is required because the IOP program has found that ongoing peer support in the community is highly beneficial to the recovering individual.

Family therapy addresses dynamics in the family system which may encourage chemical abuse. These sessions, which number from four to six, are held weekly and at the family's convenience. In session, the family is challenged to look at their interactions and seek a circular causality to the using behavior. For example, a husband who complains that his wife spends too much time at the bar with her friends is asked to consider anything he might be doing to increase her discomfort at home, as this increases "bar behavior," which then increases complaining, and so on. The family is then encouraged to restructure those negative cycles of behavior into interactions more conducive to recovery for everyone. Through family therapy, spouses and children are allowed to express to the chemical dependent how his or her behavior has affected them, and how new coping skills are affecting them now. The chemical dependent is empowered to utilize some of the new behaviors tested in group therapy and to receive feedback from the family as well.

Multi-family therapy is also offered for the families of the chemical dependents in the program. This mode of therapy provides a sense of normality and a support network for the family members. In addition, the families receive education regarding the disease process and available resources, such as Al-Anon, Al-Ateen, and Adult Children of Alcoholics (see Appendix). The families also participate in numerous group exercises regarding healthy communication, cessation of enabling behaviors, and co-dependency. All of the educational exercises are facilitated in an atmosphere of acceptance and emotional safety in

order to allow for learning in a relaxed, less intense setting. Typically, a client and his or her family will attend six multi-family sessions, for three hours, on successive Saturday mornings.

Once the chemical dependent has completed treatment, he or she is encouraged to continue attending the Aftercare group and their chosen AA or NA groups. The Aftercare group provides ongoing support in a therapeutic milieu, while the 12-step groups provide community support networks. The chemical dependent and the family members are assured that they are embarking upon a journey or a process, and that nothing changes completely overnight. They are reminded to view difficulties that confront them with patience and humor, and are provided with 24 hour access to help lines and/or their therapists.

The Intensive Outpatient Program has been in operation and has utilized this integrative approach since June of 1995. Group size averages six to 12 members at any one time during a six-week period. Multi-family group size ranges from 12 to 30 depending upon family size and participation. The membership frequently changes since these are open groups, and often one member joins as another graduates. Such an arrangement has an advantage in that new members are provided a model by veteran members, and veteran members are able to pass on some of their new-found knowledge. At the time of writing, there had been 136 clients treated in the IOP since its inception. Preliminary outcome studies suggest that the program is enjoying an estimated 65% success rate in that patients are abstinent from drugs and alcohol one year from admission.

CONCLUSION

Chemical addiction should be considered a family disease which requires intervention into the family system to truly remediate the intertwining effects upon the individual and the family. Not only does it result in negative effects such as behavior problems in children, but it impedes the basic development of the family system. In order to slow, and eventually reverse, the regression of the family' s interactions, therapy should address the development of the family rules, roles, values, problem-solving strategies, and identity. For example, the therapist could educate the family regarding healthy communication styles, and the family could design a family contract that outlines the expected and accepted behavior in the home for each member. Consequences of inappropriate behavior should be determined beforehand rather than in the heat of the moment, and the family should be

encouraged to talk about who they are and who they would like to be, as well as how they can achieve that goal.

Concurrent with family therapy, the individual substance abuser also benefits from individual therapy which explores the issues that provide him or her with a rationale to abuse substances. The abuser also profits from a 12-step program such as those sponsored by AA or NA. These programs provide the recovering addict with a guideline of development for their recovery and a mentor to assist the abuser in embarking upon the journey of recovery. This involvement is best when it is adjunctive to family therapy because it gives the abuser a chance to discuss any emerging issues with a therapist in the context of family healing.

Family members may also benefit from 12-step groups such as Al-Anon, since the group provides an outlet for venting frustrations as the family attempts to reorganize. There are a variety of Al-Anon groups, including those for adolescents (Al-ATeen), and for older children of recovering addicts (Adult Children Of Alcoholics), which address similar issues.

Although outpatient approaches are not appropriate in treating all cases of chemical dependency, a comprehensive outpatient program including these facets of recovery (i.e., family therapy and 12-step programs plus individual, multi-family, and group therapy) appears to be highly beneficial to chemical dependents and their families seeking relief from the cycle of chemical dependency. An added benefit is its cost effectiveness as compared to inpatient programs. This is a particularly significant consideration in implementing effective treatment programs in light of the strong presence of managed care policies that are increasingly commonplace among health insurance companies. Intensive outpatient programs tend to be perceived more favorably among these companies than programs utilizing inpatient hospitalization, since intensive outpatient programs are considerably less costly and more akin to the client's natural environment.

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APPENDIX: NATIONAL ORGANIZATIONS DEALING WITH SUBSTANCE ABUSE

Alcoholics Anonymous (212) 870-3400
AA World Services
PO Box 459 Grand Central Station
New York, NY 10163

Alcoholics Anonymous Homepage http://www.alcoholics-anonymous.org

The homepage for AA offers a 12–item questionnaire to assist an individual in choosing whether AA is right for him or her or not. The homepage also provides a fact file regarding statistics of AA and locations of meetings by state. Also listed are general offices and answering services in each state.

Al-Anon 1-800-344-2666

Al-Anon/Al-Ateen Homepage http://solar.rtd.utk.edu/~al-anon/eng.git96.html

The Al-Anon/AI-Ateen homepage offers general office telephone numbers by state, and meeting locations by state.

Narcotics Anonymous Homepage http://www.wsoinc.com

The NA homepage lists helplines by state, published presentation papers pertaining to NA as an organization, basic information about NA, and recovery literature and products.

Adult Children of Alcoholics Homepage http://www.intac.com/~woy/drwoititz/source.html

The ACOA homepage offers multiple resources for the healing of offspring of the alcoholic/addict.